DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

Form 5-2

DECEASED CLIENT OR EMPLOYEE REPORT

Instructions: This form should be filled out immediately upon learning of the death of any client or employee of the Department of Human Services (that meets the eligibility requirements of this policy) and sent to the Office/Division Director within three (3) days. It should then be forwarded immediately to the Department Director and the Fatality Review Coordinator.

Name of Deceased:_____

Address of Deceased:_____

Date of Birth:_____ Date of Death:_____ "O" Number:_____

Attending Physician:_____

Name and Address of Parent, Guardian or Spouse:_____

_____

Service Provider:_____ Phone Number:_____

Case Status: ❑ Open ❑ Closed Date of Closure:_____

Medical Examiner Involvement? ❑ Yes ❑ No

Deceased Person's File, Field Notes, Records, Other Documents Attached? ❑ Yes ❑ No (explain why)

Referring Worker:_____ Phone Number:_____

Division and Local Address:_____

Supervisor:_____ Phone Number:_____

Information Related to the Death:_____
_____
_____
_____
_____

Reported by:_____ Date:_____ Phone:_____